**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

OSTEOPATHIC MEDICAL CENTER OF TEXAS
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

**Respondent Name**
FACILITY INSURANCE CORPORATION

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-99-2745-01

**MFDR Date Received**
July 31, 1998

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please enter the attached claim for dispute resolution for an additional reimbursement at a rate that is 'fair and reasonable'."

**Amount in Dispute:** $9587.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Due to a PPO agreement the recommended payment was $13,589.22. However, due to a procedural error of our auditing company we paid a total of $30,923.77. We have overpaid the account in the amount of $ 17,334.55."

**Response Submitted by:** Houston General Insurance Co., PO Box 2932, Fort Worth, Texas 76113

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 29, 1997 to August 6, 1997 | Inpatient Hospital Services | $9,587.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, sets out the fee guidelines for acute care inpatient hospital services.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
   - D – Duplicate Charge
   - S – Supplemental Payment
   - C – Negotiated Contract
   - F – Reduction According to Fee Guidelines
   - 1 – (F) THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z585)
   - 2 – (C) THIS PREFERRED HOSPITAL HAS CONTRACTUALLY AGREED TO REDUCE THIS CHARGE BELOW THE USUAL AND CUSTOMARY CHARGE FOR YOUR BUSINESS. (Z557)
   - 3 – (F) THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE OR CUSTOMARY ALLOWANCE DETERMINED BY MEDICAL DATA RESEARCH. (Z560)
   - M – Reduced to Fair and Reasonable

**Findings**

1. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, requires that "A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute." The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in Hospitals and Hospital Systems v. Continental Casualty Company, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Per 28 Texas Administrative Code §102.3(a)(3), effective January 1, 1991, 15 *Texas Register* 6747, "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on date of service July 29 and July 30, 1997 was received by the Division on July 31,1998. Review of the submitted documentation finds that the request was submitted more than one year after the date of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that the requestor has not met the requirements of §133.305(a). Therefore service dates July 29 and July 30, 1997will not be considered in this review. However, the request for dispute resolution of services rendered from July 31, 1997 to August 6,1997 was submitted in accordance with the timely filing requirements of §133.305(a); therefore, these services will be considered in this review.
2. The insurance carrier denied disputed services with reason codes C – "Negotiated Contract" and 2 – "(C) THIS PREFERRED HOSPITAL HAS CONTRACTUALLY AGREED TO REDUCE THIS CHARGE BELOW THE USUAL AND CUSTOMARY CHARGE FOR YOUR BUSINESS. (Z557)" Review of the submitted information finds no documentation to support that the services in dispute are subject to a contractual agreement applicable to the parties in this dispute. The insurance carrier's denial reason is not supported. Therefore, these services will be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to inpatient hospital services with reimbursement for dates of service August 1, 1997 to August 6,1997 subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the length of stay was 6 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 6 days yields a reimbursement amount of $6,708.00.
4. Disputed services performed on July 31, 1997 were inpatient hospital services not subject to a specific fee guideline on the dates the services were rendered. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."

The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."

Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for date of service July 31, 1997 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

5. The total recommended reimbursement for the services in dispute is $6,708.00. The submitted documentation supports that the insurance carrier paid $17,334.55. No additional payment is recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor has failed to support that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | Grayson Richardson | December 11, 2013 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.